DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/10/
FORM APPRO
OMB NO. 0938-0

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505469	A. BUILDING _____ B. WING _____	06/25/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE TERRACES AT SKYLINE	715 9TH AVENUE SEATTLE, WA 98104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS This report is the result of an unannounced Quality Indicator Survey conducted at The Terraces at Skyline on 06/18/13, 06/19/13, 06/20/13, 06/21/13, 06/24/13 and 06/25/13. A sample of 26 residents was selected from a census of 32. The sample included 19 current residents, the records of nine former and/or discharged residents. Survey team members included: [redacted], MSW [redacted] RN, MN [redacted] MN [redacted], RN, BSN The survey team is from: Department of Social and Health Services Aging and Adult Services Administration Residential Care Facilities Region 2, Unit F 0425 72nd Avenue South, Suite 400 ent, Washington 98032-2388 ephone: (253) 234-6000 : (253) 395-5070	F 000		

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ntial Care Services — Date 7/10/13
)(1) RIGHT TO SURVEY RESULTS -

F 167

S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE
Interim Healthcare Director 7/11/13

nding with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that
fficient protection to the patients. (See instructions.) Except for nursing homes, the above findings and plans of correction are disclosable 90 days
whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction
documents are made available to the facility. If deficiencies are cited, an approved plan of correction

ersions Obsolete — Event ID: EOC611

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F 167	483.10(g)(1) RIGHT TO SURVEY RESULTS -	F 167		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 10-14-13

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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SS=B

Continued From page 1
READILY ACCESSIBLE

A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility.

The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability.

This REQUIREMENT is not met as evidenced by:
Based on observation and interview it was determined the facility failed to make complete survey results readily available to residents. Failure to provide access to all survey reports prevented residents from being fully informed about the facility's compliance history.

Findings include:
Observation of the facility revealed survey results binders available on both the 7th and 8th floors. Neither binder contained the most recent Life Safety Code survey. In addition, the 8th floor binder did not include the abbreviated survey conducted in March 2013 and the corresponding plan of correction. There were no signs that directed residents to where the survey results were located.

In an interview on 06/24/13 at 1:30 p.m., the Administrator stated the abbreviated survey results, as well as the Life Safety Code report should be in each of the binders. She was unaware these items were not present and stated

F 167

F167 Right to Survey results readily accessible

Corrective Action:

All survey results including the Life safety code were immediately reinstalled in the survey binder s for both 7th & 8th floor. Facility had also installed signs directing residents to where the survey results were located.

Protection of other residents:

All survey results will be installed in the survey binder by the elevator for both 7th & 8th floor.

Systemic Changes:

When survey results come to the facility, they will be installed in the survey binder by the administrative assistant in a timely manner.

Monitoring:

Monthly the Administrator will review the currency of the surveys displayed in the manual. The Administrator shall report to the Quality Assurance Committee monthly as to the completeness of the survey results.

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F 167	Continued From page 2 the binders were not regularly checked to ensure all required documents remained available.	F 167	**F176 Resident Self Administer Drugs if deemed Safe**	
F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on observation, and record review it was determined the facility failed to ensure residents were assessed for safety of medications at bedside, including self-administration, storage, and monitoring for two (#s 11 and 119) of 10 sampled residents. This failure placed residents at risk for adverse effects from receiving medications outside physician ordered parameters and exacerbation of medical conditions. Findings include: RESIDENT #11 According to the 05/24/13 Minimum Data Set (MDS), Resident #11 was assessed by staff to have clear speech, be understood and able to understand conversation. The resident's Brief Interview for Mental Status indicated she was cognitively intact. According to a Telephone Order (TO) dated 05/22/13, the resident, "may use [redacted](VS) at bedside 2x week." Observation on the morning of 06/24/13 revealed	F 176	**Corrective Actions:** Residents 11 and 119 were both discharged from the facility. **Protection of other residents:** All residents admitted to the facility will be screened on admission for appropriateness of Self-medication administration. Those that are appropriate will be educated on the facility's policy and procedure on Self-medication administration. **Systemic Changes:** The facility revised and updated its policy on Self-medication Administration. All staff will be in-serviced on the updated policy by 7/31/2013.	

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F 176	Continued From page 3 the resident had a box of VSs at her bedside. The resident stated, "I been doing my own (suppositories), I been here a whole month and they just brought that box to me today." The box of eight VSs the resident referred to, which was dispensed from the pharmacy on 05/23/13, was noted to still contain eight suppositories. The resident stated, "I take it today (Monday), not tomorrow, and then take it Wednesday, skip Thursday and take it Friday... every other day." The resident elaborated, "I am suppose to do it (administer the suppository), most of the time I do it at 7:30 a.m. when I get up in the morning, I like it at night better just before I go to bed, around 8:00 p.m." The resident was clear that she administered the medication three times one week, and four times alternating weeks, contrary to Physician Orders (PO). Review of Medication Administration Records (MARs) for May and June revealed inconsistent entries for the Vagifem VSs. On some dates, facility staff initialed the dates the medication was to be given, indicating it was administered by staff. Other entries were a checkmark, which raised the question if the medication was administered by the resident, or at all. Staff G, in an interview on 06/24/13, confirmed the MAR was not clearly reflective of the resident's receipt of medication. When asked why the resident had a box of medication which had not been used since the date of admission, Staff G stated, "She had her own supply at her bedside...". In an interview on 06/24/13 at 9:38 a.m. Staff G indicated staff should have completed a self medication assessment for Resident #11, stating, "we usually have an order from the (medical) provider that the resident may self administer	F 176	**Monitoring:** Self-medication assessment form will be added to the Medical Records audit, results of the will be reported to the Quality Assurance Committee. DNS will monitor compliance.	

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F 176	Continued From page 4 medications then the resident should be assessed if they are able to self administer...". Staff G confirmed facility staff failed to assess for the safety of or care plan the resident's self administration of medication. When informed the resident stated she was administering the medication outside physician ordered parameters, Staff G confirmed there was no mechanism in place to ensure the resident was safe to self administer medications, or who was responsible (the resident or the nursing staff) for the storage and documentation of the administration of the drug. Similar findings were identified for Resident #119 who had a 06/19/13 PO to keep Tums and muscle rub ointment at the bedside without benefit of an assessment which indicated the resident was able to safely self administer these medications.	F 176		
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined the facility failed to provide medically related social services related to end of life issues for Resident #s 121 and 12. Failure to provide supportive services placed	F 250	**F250 Provision of medically related social services** **Corrective Action:** Resident# 121 an updated care plan for grieving was immediately put in place. Resident # 12 is expired **Protection of other residents:** All residents admitted to the facility for end of life or palliative care will now be assessed by Social worker for Psychosocial care needs, referral will be made to Pastoral care if needed.	

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F 250	Continued From page 5 residents at risk for unresolved anxiety, sadness and did not assist them in achieving their highest practicable level of well-being. Findings include: RESIDENT #121 Record review revealed Resident #121, a [redacted] aged woman, admitted to the facility from a family member's home on [redacted]/13 with hospice services due to more extensive care required. The physician's progress note, dated 06/10/13, identified the resident with "emotional distress" related to some aspects of her illness. The resident "continues to express a desire to hasten her passing, and what is causing her the most distress is a sense of prolonged passing." This note also revealed the resident's spouse passed away approximately two months previous to her admission to the facility. The resident was noted to struggle "with the uncertainty of her decline. Loss of control in this situation is undoubtedly difficult." The physician then recommended a Palliative Consult and noted an "urgent referral has been placed" for palliative services. The physician identified her "hope is that they can discuss end of life goals, and help the pt process the sense that she has no control in this process." There was no indication hospice was notified of this assessed need or that the facility social worker became involved to assist the resident in processing her grief. In addition, there was no indication in the record that a palliative consult occurred. The record revealed the hospice chaplain visited the resident on two occasions. On 06/12/13 the resident was noted to find "little joy in life", to exhibit depression and to speak of the recent loss	F 250	**Systemic Changes:** Facility implemented a new policy and procedure for end of life care. Facility staff will be in-serviced on this new policy by 7/31/2013. **Monitoring:** Social services will ensure appropriate referral is made as needed. DNS will conduct spot audits and monitor compliance. RECEIVED OCT 15 2013 DSH/JADS/MRCS	

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F 250	Continued From page 6	F 250		

of her spouse. On 06/19/13, the chaplain identified the resident with a "low mood, unsmiling... continues to exhibit lethargy, sadness, a sense of defeat... going towards death with a great deal of sadness."

The resident's record revealed no social service notes other than a Discharge Assessment, which indicated the resident had no discharge plans and was on hospice services. There was no indication the facility chaplain visited the resident.

In an interview on 06/24/13 at 1:20 p.m., Staff C, Social Services, stated the resident was a new admission and had not been at the facility long enough for Social Services to "really get involved". Staff C stated she periodically visited the resident to greet her, however the resident often had a visitor or seemed tired and so she had not provided more than a brief visit. She stated she had not documented any of those visits or the resident's response to them. Staff C stated she had not referred the resident to the facility chaplain and she did not know if chaplain visits had been provided. She stated, "there would be notes in the chart if the chaplain visited." No notes were located in the resident's record. Staff C stated she would follow-up with the facility chaplain to request supportive visits for the resident. When asked to explain the facility's plan to provide end of life support to Resident #121, Staff C stated, "Well, she has hospice."

In an interview on 06/21/13 at 9:00 a.m., Resident #121 was sitting in a chair at her bedside. She was slow to answer questions, but stated she appreciated the visit. She became tearful when she spoke of her concerns about how her family would handle her death. Resident #121 stated

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F 250	Continued From page 7 she was attempting to come to terms with her prognosis but she exhibited signs of grief as she spoke about the end of her life. In an interview on 06/25/13 at 8:15 a.m. Staff C stated she was unaware of the hospice and facility physician's notes regarding the resident's difficulty with end of life. While she explained hospice was involved in order to provide needed support to the resident, she acknowledged hospice was not present daily and additional support could be helpful to Resident #121. RESIDENT #12 According to the resident's record, she admitted to the facility on [redacted]/13 with a diagnosis of [redacted] in addition to multiple other illnesses. The resident passed away on [redacted]13. In an interview on 06/21/13 at 8:37 a.m., Staff D stated the resident was told by facility staff her husband passed away on [redacted]/13. Staff D further explained while the resident's spouse was taken off life support on that day, he actually passed away on [redacted]/13, which was then explained to the resident. The Social Services psychosocial assessment, dated 04/23/13, identified the resident's goal was to return home to her husband. There was no note regarding the death of her spouse, an assessment of how she was coping or what emotional needs she might have, nor a plan on how the facility might provide for her needs related to grief. According to the physician's note, dated 04/24/13, the resident's spouse was in the hospital and "not doing well". She indicated if the resident recovered she would likely remain at the facility	F 250		

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F 250	Continued From page 8	F 250		

permanently. The physician indicated she spoke to the resident's family regarding her "poor" prognosis.

A consult note, dated 04/24/13, indicated the resident experienced "debility and decondition- despite rather aggressive medical support, (resident's) malnutrition, functional decline, and lethargy continues to indicate a poor prognostic picture. Added to this is the very recent death of her husband... (family) expressed some desire to focus on comfort particularly (resident's) emotional state".

Activity staff noted on 04/15/13 the resident "talked about husband and many changes in her life"; on 04/17/13, the resident was "tearful concerned about her husband"; and on 04/28/13, the resident was "tearful... very sad on death of husband...".

In an interview on 06/21/13 at 8:37 a.m., Staff D stated after the resident's spouse died, "she really just shut herself off". Staff D explained the resident did not want to eat and became more lethargic and weak. She stated on 04/23/13 the facility recognized the decline and anticipated the resident "was going to pass." Staff D acknowledged there was no care plan related to the resident's decline or the family's decision to initiate comfort care measures. She stated, "there should be a care plan for comfort care".

Staff D further stated the facility discussed hospice services with the resident's family, however she was unable to locate any notes that indicted when that occurred or what the family decided. Staff D stated "It looked like she was going quickly so we opted for comfort care only."

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F 250	Continued From page 9 In an interview on 06/21/13 at 9:35 a.m., Staff C stated she was aware Resident #12's spouse had passed away. Staff C explained in those types of situations, she would typically develop a care plan related to the resident's grief. She stated she would "offer and provide support... make referral to pastoral service...". Staff C stated there were no notes in the resident's record to support a referral had been made to the facility chaplain or that the chaplain had provided visits to the resident. Staff C reviewed the resident's record and her notes and acknowledged there was no mention of the resident's husband dying, no indication of a plan to provide support, and no identification of interventions staff might implement to assist the resident in coping with her grief and poor prognosis after the change to comfort care. Staff C stated, "Of course there should be Social Service interventions." Staff C stated while she remembered talking to the resident she failed to make a record of any support she provided, nor did she develop a plan so other staff could provide appropriate support. Staff C stated she recalled the resident saying she didn't care anymore and that she just wanted to die and be with her husband. She was unable to state what, if anything, she had done regarding that statement in order to assist the resident with her grief.	F 250		
F 272 SS=E	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.	F 272		

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F 272	Continued From page 10 A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined the facility failed to accurately assess two (#s 48 & 21) of two	F 272	**F272 Comprehensive Assessments** **Corrective Actions:** Resident # 21 was discharged to the facility Resident # 48 miscoding was immediately corrected on 6/27/13 Resident# 72 miscoding for falls and weight was immediately corrected on 6/27/2013. The facility's computer system parameter for weight calculation was corrected. Dietary tech double checked the weight report for accuracy. Resident# 96 miscoding for weight was immediately corrected on 6/27/2013. Resident# 6 miscoding for medications was immediately corrected on 6/27/2013. Resident# 70 miscoding for incontinence was immediately corrected on 6/27/2013. Resident# 115 miscoding for catheter justification was immediately corrected on 6/27/2013.	

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F 272	Continued From page 11 residents reviewed for dehydration, three (#s 40, 72 & 96) of three residents reviewed for nutrition, one (#72) of three residents reviewed for accidents, one (#6) of three residents reviewed for pain, and two (#70 & 115) of four residents reviewed for urinary status. These failures placed residents at risk for unidentified and/or unmet needs. Findings include: RESIDENT #21 According to the 02/17/13 Minimum Data Set (MDS), Resident #21 experienced dehydration. The 02/10/13 MDS did not identify this as an issue. Review of her closed record revealed the resident had diagnoses to include [redacted] chronic [redacted], and [redacted] According to a physician's progress note, dated 02/20/13, the resident was "noted to have acute [redacted] injury after complaining of generalized fatigue. She responded well to IV hydration" and her creatinine "returned to base line". She was noted to have Hypercalemia / acute kidney injury with a history of chronic kidney disease. The Nutrition Risk Review, dated 02/07/13, noted the resident's hydration needs were not always met, however there was no mention of dehydration or a need for increased fluid intake. The resident was started on IV fluids on 02/16/13 due to lab results that were low. There was no mention in the nurse or physician progress notes that the low results were due to dehydration. In an interview on 06/21/13 at 12:57 p.m., Staff D, MDS Coordinator, stated while there was not a diagnosis of dehydration, she based the MDS	F 272	**Protection of other residents:** The facility has and continues to ensure residents have a comprehensive assessments. The MDS nurse now has access to the incident Logs to ensure accuracy of coding falls. The Registered Dietician will now be completing section K of the MDS to ensure accurate coding for any weight loss or dehydration. **Systemic Changes:** Facility reviewed and updated it's Policy & Procedure on Weight Monitoring, all residents weights will be reviewed by the Nutrition at Risk Committee weekly for accuracy and discrepancy. Residents with weight discrepancy will be re-weighed within 24 hours. Licensed Staff will be in-serviced of the updated policy by 7/31/2013. MDS nurse will also be sent for MDS coding class by 7/31/2013.	

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F 272	Continued From page 12 coding on the IV fluids the resident received. She acknowledged staff did not consistently monitor the resident's intake and output, nor was there a plan to treat dehydration outside of the IV fluids. She stated the IV fluids appeared to be used to treat low lab values due to renal disease and that while she originally based her assessment on the IV, the resident did not appear to meet the criteria for dehydration. RESIDENT #48 According to the 04/03/13 MDS, the resident was assessed as dehydrated. Review of the resident record revealed no indication or diagnosis of dehydration. In an interview on 06/21/13 at 11:12 a.m., Staff D stated, "The MDS was coded in error, the resident wasn't dehydrated." RESIDENT #72 In an interview on 06/18/13 at 1:43 p.m. Staff G said Resident #72 experienced several falls in the past 30 days, all due to self transferring. According to the 05/25/13 MDS, the resident required two person assist with transfers and had fallen only once since the prior MDS dated 02/26/13. According to the care plan, Resident #72 fell six times between 02/26/13 and 05/24/13. According to the Incident Log, the resident fell seven times in the same period with differing dates. In an interview on 06/21/13 at 10:15 a.m. Staff D indicated she had coded the MDS to represent the number of falls in a 30 day period rather then since the prior MDS as directed. Staff D said the MDS should have been coded to accurately reflect the resident's number of falls.	F 272	**Monitoring:** DNS or designee will conduct Quality Assurance /Quality improvement audits to ensure continued compliance. The DNS/ designee will conduct the audits quarterly, the results of the audits will be reported to the Quality Assurance Committee.	

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F 272	Continued From page 13 Additionally, according to the 05/25/13 MDS, the resident weighed 88 pounds (lbs) and had no significant weight (wt) change as evidenced by a difference of 5% in the last month or 10% in six months. Review of facility weights revealed the resident was 88.2 lbs on 05/20/13 and 98 lbs on 12/21/12, which constituted a 9.8 lb wt loss or 10% in six months. In an interview on 06/25/13 at 9:33 a.m. Staff D said the computer did not always calculate weight loss correctly and the MDS should have been coded to reflect the resident's significant weight loss. RESIDENT #96 Resident #96 was admitted to the facility on [redacted]13. The first wt documented at the facility was 113 lbs on 03/20/13. On 04/08/13 the listed wt was 99 lbs which was 14 lbs less than at admission, or a 12.4% wt loss. According to the 04/14/13 MDS the resident weighed 99 lbs and experienced no significant wt loss. In an interview on 06/21/13 at 10:18 a.m. Staff D said the resident's wt during the assessment period was 99 lbs on 04/08/13 and 102 lbs on 04/15/13, which the computer calculated as a 3.13% wt loss from admission. Staff D indicated it was an error and the MDS should have been coded to reflect the resident's significant wt loss. Similar findings were identified for Resident #40 whose weight records indicated he experienced a	F 272		

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F 272	Continued From page 14 15% weight loss between 12/12 and 05/13, but whose MDS did not accurately reflect a significant weight loss. RESIDENT #6 In an interview on 06/19/13 at 12:50 p.m. Resident #6 said she had three back surgeries, rheumatoid arthritis and was on regularly scheduled morphine. According to the 05/23/13 MDS, the resident was not on a scheduled pain management regimen, but experienced significant pain almost constantly which made it hard to sleep at night and limited day to day activities. Review of the resident's record revealed [redacted] had been routinely scheduled since 05/09/13. Additionally, the resident had physician's orders for a daily [redacted] since 05/09/13, which was not identified on the 05/23/13 MDS. In an interview on 06/25/13 at 9:33 a.m. Staff D acknowledged the MDS did not accurately reflect the medications the resident received. RESIDENT #70 Resident #70 was admitted to the facility on [redacted]/12. According to the 12/28/12 Admission MDS, the resident had chronic [redacted] required extensive assistance of one to toilet, did not have a catheter and was continent of urine. According to the 30-day MDS, dated 01/18/13, and the 60 day MDS, dated 02/15/13, the resident remained continent. The 03/20/13 Quarterly MDS assessed the resident as frequently incontinent. Review of Resident #70's record revealed a	F 272		

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F 272	Continued From page 15 12/21/12 Admission Bladder Evaluation which indicated the resident was incontinent on admission, with daily incontinence episodes. In an interview on 06/24/13 at 8:14 a.m. Staff G said Resident #70 had intermittent incontinence at home prior to admission to the facility. In an interview on 06/24/13 at 8:41 a.m., Staff D said data regarding a resident's continency was computer generated based on data inputted into the CNA care system (CareTracker). Review of the entries in Care Tracker for the assessment periods of the above MDS' revealed the resident was incontinent, most often during night shift, in the early morning hours. Staff D said all of the the MDS' should have been coded to reflect the resident as incontinent. RESIDENT #115 In an interview on 06/18/13 at 1:30 p.m. Staff G said Resident #115 had a urinary catheter for the diagnosis of urinary retention. On 06/20/13 at 9:11 a.m. Resident #115 was observed with a catheter in place. While the 06/08/13 MDS indicated the resident had an indwelling catheter, it did not identify a justifying diagnosis. In an interview on 06/21/13 at 10:18 a.m. Staff D said the MDS should have noted the diagnosis of retention.	F 272		
F 279 SS=E	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.	F 279	**F279 Comprehensive Care plans** **Corrective Actions:** Resident # 123 was discharged from the facility Resident# 40 Care plan was corrected to accurately reflect current status and have measurable goals and timely goal dates. Resident#22 was discharged from the facility Resident#96 was discharged from the facility	

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F 279	Continued From page 16 The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to develop and/or revise comprehensive care plans for six (#s 123, 40, 22, & 96) of 22 sample residents reviewed for care plans. Failure to establish care plans that accurately reflected assessed care needs and provide direction to staff on the residents' care related to end of life, mood and behaviors, hearing aids, urinary status, nutrition and psychoactive medication use placed residents at risk to receive less than adequate care. Findings include: RESIDENT #123 Review of the admission care plan, dated [redacted]13, noted the resident had hearing aids that were kept at her bedside at night. The Medication Administration Record contained a notation that	F 279	**Protection of other residents:** The care plans of residents with falls, weight loss, incontinence and catheter are being reviewed to ensure the plan of care continues to accurately reflect the resident's status and has measurable goals. **Systemic Changes:** On admission, upon significant change in resident status and residents come due for their next MDS assessment, the resident's care plans will be reviewed to ensure the care plans continue to accurately reflect the resident's status and have measurable goals and timely goal dates. The facility has also implemented weekly interdisciplinary care planning meeting to capture any changes to the resident's care plans. Licensed staff will be in-serviced on the new policy by 7/31/2013.	

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F 279	Continued From page 17 the "hearing aids are given to the nurse and locked in the med cart per the family's request." On 06/21/13 at 10:06 a.m., the resident's family was observed to ask Staff G for the resident's hearing aids, which were locked in the medication cart. At that time Staff G stated the admission care plan (CP) should have been revised. RESIDENT #40 Review of Resident #40's behaviors, mood state and dementia CPs revealed the goal date as 03/22/13. An approach for the Impaired Behaviors CP directed staff to "avoid the following triggers" however no triggers were identified. The Mood State CP included the approach "followed by [redacted] for med review." The record revealed the last mental health visit was 06/20/12 and the 06/14/13 [redacted] Review noted the resident's [redacted] health services had been discontinued. In an interview on 06/24/13 at 1:15 p.m., Staff C stated she updated CPs quarterly and as changes occurred. She stated she must have missed Resident #40's. In an interview on 06/25/13 at 8:15 a.m., Staff C stated she updated the goal dates for Resident #40. She did not, however, review the interventions and revise them to accurately indicate the resident no longer received mental health services, nor were triggers for his behaviors added. RESIDENT #22 Review of Resident #22's record revealed a diagnosis of [redacted] and administration	F 279	**Monitoring:** DNS or designee will conduct random Quality Assurance/Quality Improvements audits to ensure continued compliance. The audits will be reported to the Quality Assurance Committee.	

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F 279	Continued From page 18 of an a[redacted]medication. A care plan was in place for the use of the medication related to potential side effects, however there was no CP that identified how the resident's [redacted] might manifest itself or how her [redacted] would be managed in non-drug ways. In an interview on 06/25/13 at 8:32 a.m., Staff C stated a CP should be in place due to the resident's diagnosis and use of the anti-depressant. RESIDENT #96 Resident #96 was admitted to the facility on [redacted]/13. The first documented weight (wt) at the facility was 113 pounds (lbs) on 03/20/13. The 03/21/13 Nutrition Risk Review indicated the resident had significant wt gain as the resident's usual body wt was 102.8 lbs. The 03/21/13 Nutritional Status CP indicated the resident was at nutritional risk as evidenced by a hip fracture, dementia and unplanned weight gain. The identified goal was "Resident will have no significant weight change i.e. less than 2% x 1 wk, less than 5% x 1 month, less than 7.5 % x 3 months, less than 10% x 6 months." Approaches included a regular diet, meal monitor, weekly wts and ordered supplements. Review of the weekly wts revealed a 04/04/13 wt of 101 lbs which was 12 lbs. less than at admission or a 10.6% loss, and a 04/08/13 wt of 99 lbs which was 14 lbs. less than at admission or a 12.4% loss. The only dietary note/assessment was the admission note dated 03/21/13. There were no	F 279		

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F 279	Continued From page 19 changes to the CP after the resident sustained a significant wt loss.	F 279		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use [redacted] drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined the facility failed to ensure residents had adequate indications, monitoring, and/or non drug interventions for [redacted] medications for three (#s 11, 124 &	F 329	**F329 Drug regimen is free from unnecessary Drugs** **Corrective Actions:** Resident# 11 was discharged from the facility Resident#124 PRN [redacted] medication was discontinued on 7/9/2013. Resident# 119 was discharged from the facility. **Protection of other residents:** Any residents on [redacted] medications that have potential to be affected by this practice. Licensed nurses will receive training on utilization of [redacted] medications, interventions (including non-drug interventions) prior to administering and proper documentation.	

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F 329	Continued From page 20 119) of 10 residents reviewed for unnecessary medications. These failures placed residents at risk for adverse side effects or to receive unnecessary medications. Findings include: Refer to CFR 483.25, F-309 Care and Services RESIDENT #11 Resident #11 was admitted to the facility on [redacted]13 with care needs related to a [redacted] and infection. According to the 05/24/13 Admission Minimum Data Set (MDS), the resident had a diagnosis of [redacted] and was assessed to experience pain almost constantly which made it difficult for the resident to sleep at night and limited day to day activities. The resident rated her pain as a "10" on a scale of 1-10. According to this MDS Resident #11 had no behaviors and no rejection of care. According to the facility's [redacted] Medication policy, "[redacted] medication therapy shall be used only when it is necessary to treat a specific condition." Review of May 2013 Medication Administration Records (MARs) revealed Resident #11 received as needed (PRN)[redacted] (an anti-anxiety/benzodiazepine) medication on 05/18, 21 and 22/13 without benefit of non drug interventions prior to it's administration. Target Behavior (TB) sheets, the facility's system for tracking behaviors, their severity and interventions, were not initiated until 05/23/13. Administration of anti-anxiety medications prior to attempting non drug interventions constituted the use of an unnecessary drug.	F 329	**Systemic changes:** Licensed nurses will be educated on non-pharmacological interventions prior to usage of PRN medications. The Licensed nurses will also be educated on reviewing care plans for the non-pharmacological interventions by 7/31/2013. Facility also reviewed and updated it's policy on [redacted] medication. **Monitoring:** DNS or designee will conduct random Quality Assurance audits to ensure continued compliance. The audits will be reported to the Quality Assurance Committee.	

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F 329	Continued From page 21 In an interview on 06/24/13, Staff D indicated TB sheets should be initiated on admission or with the addition of a psychotropic medication which required monitoring. Staff D was unable to explain why Resident #11's TB record wasn't started until 05/23/13. Failure to provide adequate monitoring detracted from staff's ability to track and trend resident behaviors. In addition, review of May 2013 MARs revealed a physician's order (PO) for [redacted] each evening "for sleep" which the resident received on 05/21 &22/13. According to the 2012 Beers Criteria for Potentially Inappropriate Medication Use in Older Adults, "In general, all benzodiazepines increase risk of cognitive impairment, delirium fall, fractures... in older adults... Avoid benzodiazepine (any type) for treatment of insomnia...". Facility staff failed to identify the contraindication of the use of this medication or provide medical justification for its use to treat insomnia. On 05/29/13 at 12:30 p.m. and 5/31/13 at 9:00 a.m., staff documented the concomitant administration of PRN pain and anti-anxiety medication. Similar findings were identified twice on 06/01/13 and once on 06/04 and 11/13. On these days and on 05/30/31, 06/02, 05, 10, 12 and 19/13, the resident received PRN anti-anxiety medication without benefit of non drug interventions. Additionally, of these PRNs administered in June 2013, TB records reflected the resident demonstrated anxious behaviors only on 06/10/13 In an interview on the morning of 06/25/13 Staff G staff stated should not administer pain and anti-anxiety medications at the same time, rather	F 329		

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F 329	Continued From page 22 staff should rule out pain as a contributing factor to anxiety prior to the administration of anti-anxiety medications. Staff G also stated facility staff should attempt non drug interventions and document them on the TB sheet prior to the administration of psychoactive PRN medications. Additionally, according to May 2013 MARs the resident received a fleets phosphate enema on 05/20/13 when it was not indicated by PO, and in place of less invasive bowel medications which were ordered, rendering the enema an unnecessary medication. Similar findings were identified for Resident #124 who received PRN anti-anxiety medication on 06/08, 09, and 06/11/13 with no evidence of non drug interventions and TBs which did not consistently reflect the resident demonstrated behaviors which required the use of PRN psychoactive medications. Administration of psychoactive medication without adequate indication for use placed the resident at risk to receive an unnecessary medication. In an interview on 06/24/13 at 11:35 a.m., Staff D stated, "there should be non drug interventions." Similar findings were noted for Resident #119 who received Ambien for insomnia on 06/18/13 and melatonin on 06/19, 20, 21, 22, 23 and 06/24/13 without monitoring the hours of sleep. In an interview on 06/25/13 at 9:33 a.m. Staff D said a sleep monitor should have been on a behavior monitor sheet in the MARs. Failure to provide adequate monitoring detracted from staff's ability to assess the efficacy and necessity of the medications.	F 329		

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F 332 SS=E	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined the facility failed to ensure a medication error rate of less than 5%. Two Licensed Nurses (Staff I and K) failed to follow physician's orders and/or manufacturer's recommendations for three of 25 medications which resulted in a medication error rate of 12% with three (#s 119, 15, & 6) of 10 residents reviewed experiencing medication errors. These failures placed residents at risk to experience adverse side effects or less than the intended therapeutic effects of medications. Findings include: RESIDENT #119 Observation of medication pass on 06/25/13 at 8:23 a.m. revealed Staff I prepare and administer 40 milligrams (mgs) of [redacted] (an injectable medication to prevent blood clots) to Resident #119. Staff I was observed to knock the side of the syringe with her finger to get the air bubble to rise to the top, then depress the plunger, which expelled the air, along with some of the medication from the syringe. Staff I then injected the medication into Resident #119's abdomen below the belly button. Resident #119 was noted sitting upright in a wheelchair at the time. According to the Nursing 2013 Drug Handbook, located at the nurse's station as a reference for	F 332	**F332 Free of Medication Error rates of 5% or more.** **Corrective Action:** Resident#119 suffered no adverse outcomes related the improper med administration of the [redacted] Staff I was educated on the proper administration of the drug based on Nursing 2013 Drug Handbook and manufacturer's administration recommendation. Resident# 15 suffered no adverse outcomes related to the improper medications administration to be given 30 minutes after same meal each day. Staff I was educated on proper administration of the drug based on the Nursing drug Handbook 2013 and manufacturer's administration recommendation.	

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	505469	A. BUILDING _____ B. WING _____	06/25/2013

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F 332	Continued From page 24 nursing staff, directions for subcutaneous [redacted] included, "With patient lying down, give by deep subcutaneous injection, alternating doses between left and right anterolateral and posterolateral abdominal walls." There was also a red "alert" for this medication which read, "Don't try to expel the air bubble from the 30 or 40 mg prefilled syringes. This may lead to loss of drug and an incorrect dose." In an interview on 06/25/13 at 9:35 a.m., Staff I stated she was not aware [redacted] needed to be injected as deep subcutaneous, or that the air bubble was not to be expelled from the prefilled syringe. Failure to follow manufacturer's guidelines had the potential to detract from the intended effectiveness of the medication and resulted in one medication error. RESIDENT #15 Observation of medication pass on 06/25/13 at 8:32 a.m. revealed Staff I prepare multiple medications for Resident #15, including [redacted] (a mediation to treat prostate problems). Upon entering the resident's room, an unconsumed breakfast tray was noted in front of the resident. The resident stated he drank his juice but was waiting for staff to bring him an alternate tray. Staff I proceeded to administer the medications to Resident #15, during which time the resident received his alternate meal. The bingo card for the [redacted] included the instruction, "give 1/2 hour after meals." According to the Nursing 2013 Drug Handbook the medication should be given, "30 minutes after same meal each day." In an interview on 06/25/13 at 9:35 a.m., Staff I	F 332	Resident#71 suffered no adverse outcomes related to the improper med administration of Pred Forte 1% eye drops. Staff K was educated on the proper administration of the drug based on Nursing 2013 Drug Handbook and manufacturer's administration recommendation. Resident# 6 suffered no adverse outcomes from the medication error. Staff K was educated on the 5 rights of medication administration and following MD orders. **Protection of other residents:** All residents potentially affected by this deficient practice, all licensed nurses will be in-service by Pharmacy Consultant on the basic drug administration techniques, following MD orders and transcription of orders by 7/31/2013.	

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F 332	Continued From page 25 indicated she thought the bingo card directed the medication to be given, "1/2 hour" before the meal. Staff I confirmed the medication was not given as instructed. Failure to administer medications as directed had the potential to detract from its efficacy and constituted a medication error. RESIDENT #6 Observation of medication pass on 06/24/13 at 11:00 a.m. revealed Resident #6 request pain medication, for knee and back pain at a level of eight out of 10. At 11:07 a.m. Staff K was observed to administer Resident #6 three tablets of hydromorphone HCL 2 mg, for a total of 6 mg. Review of the resident's record revealed a 06/20/13 Physician's order for hydromorphone HCL 2 mg tab; give 2 tabs as needed for pain scale of 8-10, give 3 tabs for pain scale of greater than 10. Based on the resident's response of pain at level eight the resident should have received a total dosage of 4 mg rather than the 6 mg administered. In an interview on 06/24/13 at 12:40 p.m. Staff K said the resident wanted three tablets at that pain level. She indicated the prior month's Medication Administration Record read 3 tabs for pain level 7-10 and Staff K believed the current order was incorrectly transcribed. Failure to administer the dose as ordered constituted one medication error.	F 332	**Systemic Changes:** The facility reviewed and updated it's policy and procedure on Med Administration, transcription or doctor's orders. Licensed nurses will be in-serviced on these changes by 7/31/2013. **Monitoring:** The resident Care Coordinator will conduct random audits weekly, these audits will be reported to the DNS and reported to the Quality Assurance Committee. DNS will monitor and ensure compliance.	
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency	F 425	**F425 Pharmaceutical SVC Accurate Procedure, RPH** **Corrective Actions:** Resident#40 order for Miralax was immediately corrected and clarified with MD.	

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F 425	Continued From page 26 drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined the facility failed to clarify Physician's Orders and ensure medications were administered according to manufacturer's recommendations for three (#s 23, 11 & 40) of ten residents reviewed for unnecessary medications. These failures placed residents at risk for untreated medical conditions and medication errors. Findings include: RESIDENT #23 Review of the Resident #23's Medication Administration Record revealed Resident #21 received the antibiotic [redacted] at 8:00 a.m.	F 425	**Protection of other residents:** Residents with similar order for [redacted] will be audited, these orders will be clarified by 7/31/2013.Licensed Nurses was educated on the facility policy on transcription of orders and 24 hour physician audits. **Systemic Changes:** The facility reviewed and updated it's policy on medication transcription. Licensed nurses will be educated on the changes to the policy by 7/31/2013. **Monitoring:** The facility currently have in place 24 hours physician audit for accuracy of order transcription, the pharmacy consultant reviews all orders quarterly , these orders are also reviewed monthly during recaps. DNS will conduct random audits to ensure compliance. Results of the audits will be reported to the Quality Assurance Committee.	

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F 425	Continued From page 27	F 425		

and 8:00 p.m. each day from 05/25 through 05/31/13. In addition, she received a multivitamin with mineral, which included four milligrams of Zinc every day at 8:00 a.m.

According to the Nursing 2013 Drug Handbook, located at the nurse's station as a reference for nursing staff, drug interactions included: "...products containing zinc: may decrease ciprofloxacin absorption and effects. Give ciprofloxacin 2 hours before or 6 hours after these drugs"

In an interview on 06/25/13 at 10:59 a.m., Staff D stated she had inquired with the pharmacy and staff should not have administered these medications together.

RESIDENT #11
Record review revealed Resident #11 was admitted to the facility on [redacted]/13 with an order for [redacted]"1-2 tabs". Upon admission, the physician indicated 2 tablets should be administered. However, upon reviewing the POs for June, the order was written as "1-2 tabs". The record contained POs for May and June, both signed by the physician on 06/19/13 indicating different directions.

In an interview on 06/25/13 at 9:46 a.m., Staff D confirmed the [redacted]order should have been clarified as it appeared the pharmacy failed to transcribe the order to the June POs because they did not receive a copy of the admission orders on which the physician originally demarcated two tabs.

RESIDENT #40
Review of Resident #40's record revealed a PO,

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F 425	Continued From page 28 dated 05/07/12, for "[redacted]Mix 8.6gm (grams) with water or juice and drink every day (Give 1/2 dose)." In an interview on 06/25/13 at 9:32 a.m., Staff D stated the order was unclear and should have been clarified by staff. In an interview on 06/25/13 at 9:52 a.m., Staff G stated it was not clear if staff were to administer 4.3 grams of [redacted] or if the 8.6 was a half dose (as the usual dose was 17 grams). He stated "It isn't clear. Needs clarified."	F 425		